DBT Skills for Everyday Wellbeing: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



DBT Skills for Everyday Wellbeing: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 12 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

This guide accompanies the DBT Skills for Everyday Wellbeing programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 9. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the DBT Skills for Everyday Wellbeing programme as guided self-help: a short supported contact after each of its 12 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 12 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: dialectical behaviour therapy, the biosocial theory, the dialectic of acceptance and change, and how the twelve modules are built
- Chapter 2, What the research shows: the evidence for DBT and for its skills taught on their own, and its limits

CHAPTER 1

The model behind the programme

Where DBT comes from

Dialectical behaviour therapy was developed by Marsha Linehan in the 1980s and 1990s, first for women with chronic suicidal behaviour and a diagnosis of borderline personality disorder (Linehan, 1993). Standard cognitive behavioural therapy, with its emphasis on change, was experienced by many of these clients as invalidating: being asked to change, again and again, by someone who did not seem to grasp how unbearable things were. Therapies built only on acceptance, on the other hand, left them in that unbearable place. DBT's answer was to hold both at once, and to teach the skills that people with intense emotions had never had the chance to learn.

Standard DBT has four parts: weekly individual therapy, a weekly skills training group, telephone coaching between sessions, and a consultation team for the therapists. The skills group teaches four sets of skills (Linehan, 2015). This programme offers that skills curriculum, adapted for self-help with a practitioner's support. It does not offer the other three parts, and it is not a substitute for full DBT for people who need it.

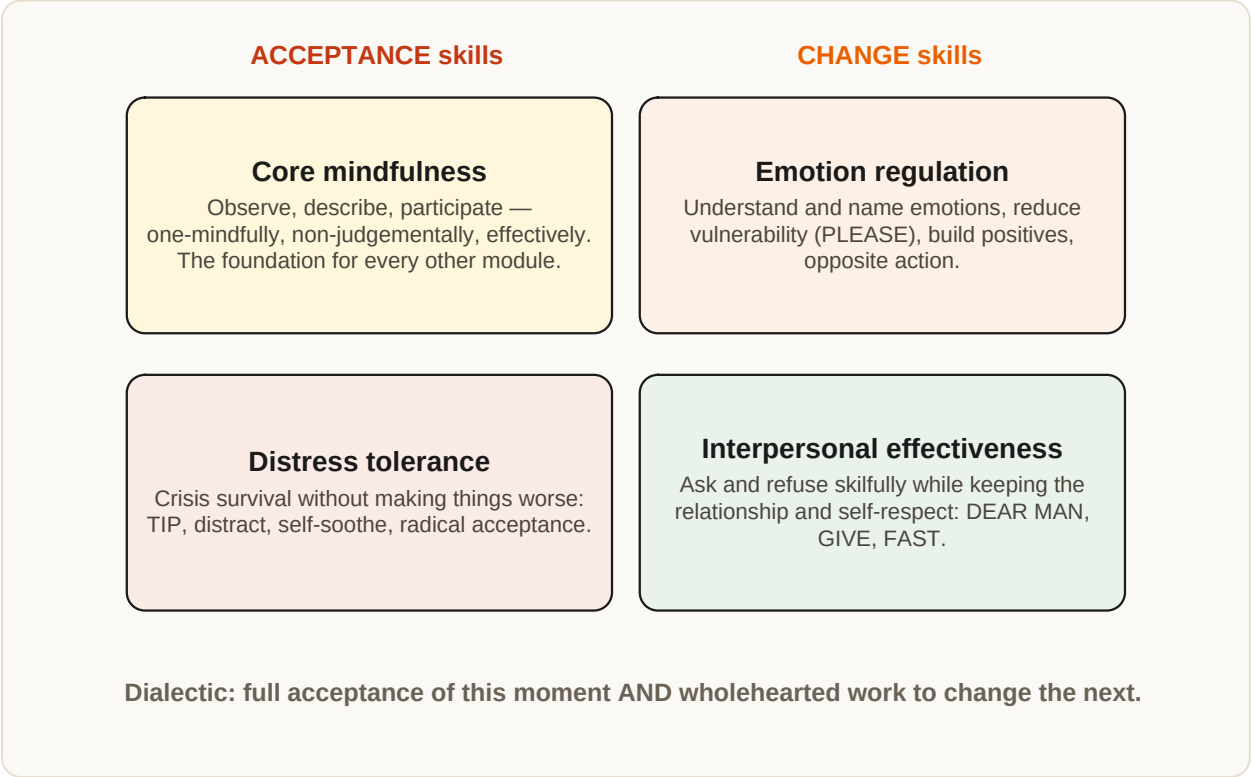


FIGURE 1.1 The four DBT skills modules
Linehan's skills curriculum balances acceptance and change. Mindfulness and distress tolerance teach how to be with experience as it is; emotion regulation and interpersonal effectiveness teach how to change it. Core mindfulness underpins all three of the others.

The biosocial theory

The theory behind DBT explains why some people's emotions become so hard to manage, without blaming them or the people around them. It proposes that the difficulty arises from a transaction between two things over many years: a biological emotional vulnerability (emotions that are triggered easily, are felt intensely, and are slow to return to baseline) and an invalidating environment, in which the person's emotional experience was dismissed, punished or treated as wrong, so that they never learned to name, trust or regulate it. Crowell, Beauchaine and Linehan (2009) extended the theory with developmental evidence, describing how early impulsivity and emotional sensitivity, met by invalidation, can shape a person's way of coping over childhood and adolescence.

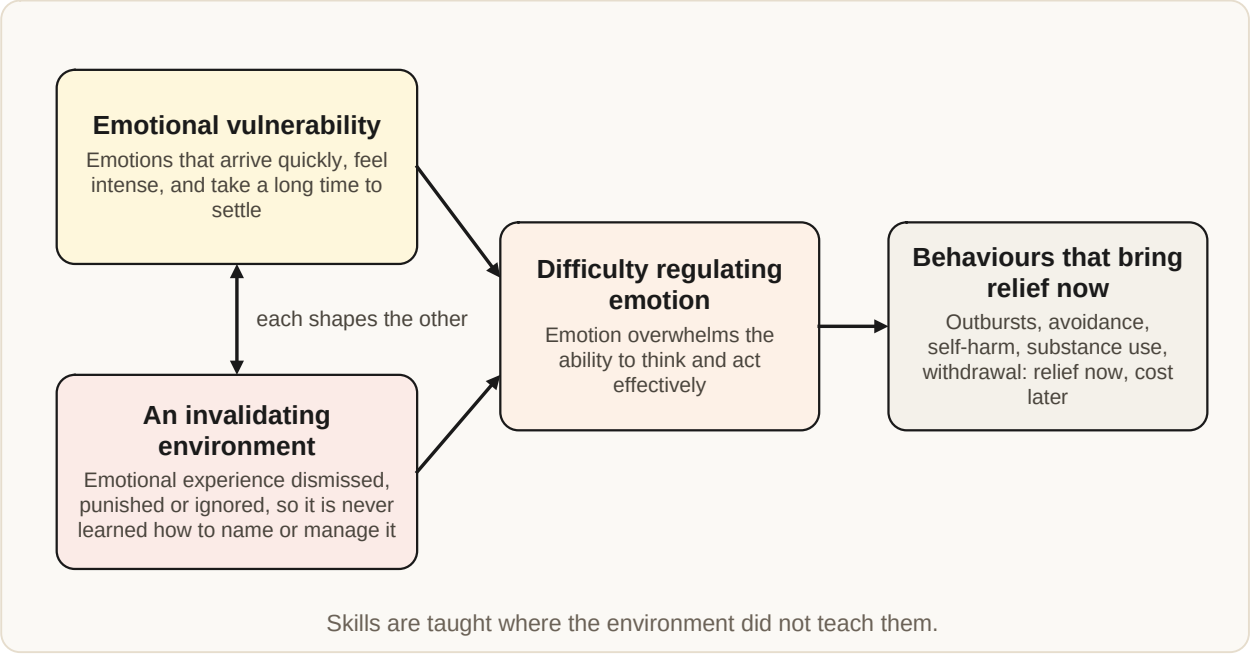


FIGURE 1.2 The biosocial theory of emotional difficulty
Linehan's biosocial theory: a biological sensitivity to emotion, meeting an environment that dismisses or punishes emotional experience, leaves a person without the skills to regulate emotion. The behaviours that follow bring short-term relief and long-term cost. The theory explains the difficulty without blaming the person or the people around them.

The theory matters in practice for three reasons. It is the first thing clients learn in the programme, in module 1, and many find it a relief: their reactions make sense. It explains why the programme teaches skills rather than insight, since what was never learned can be learned now. And it points to validation as something the practitioner offers in every contact: an environment that takes emotional experience seriously is part of what helps.

The dialectic of acceptance and change

"Dialectical" refers to holding two apparently opposite positions together and finding what is true in both. The central dialectic is acceptance and change: the client is doing the best they can, and they need to do better; they need to accept themselves as they are, and they need to change. In the programme this appears in the balance of the skill sets. Mindfulness and distress tolerance are skills of acceptance: noticing experience as it is, and getting through a painful moment without making it worse. Emotion regulation and interpersonal effectiveness are skills of change: altering the emotions themselves, and asking for what one needs.

For the practitioner, the dialectic is a stance as well as a model. Contacts work best when they move between validating the client's difficulty and expecting practice, rather than settling at either end.

How the twelve modules are built

The programme takes the four skill sets in a deliberate order. Module 1 orients the client: what DBT is, the dialectic, the biosocial theory, and their goals for the twelve weeks. Mindfulness comes next (modules 2 to 4), because every other skill depends on noticing what is happening in the moment. Distress tolerance follows (modules 5 to 7), so that the client has ways through a crisis

early in the programme. Interpersonal effectiveness (modules 8 and 9) and emotion regulation (modules 10 to 12) complete it, and the last module ends with a plan for keeping the skills in use.

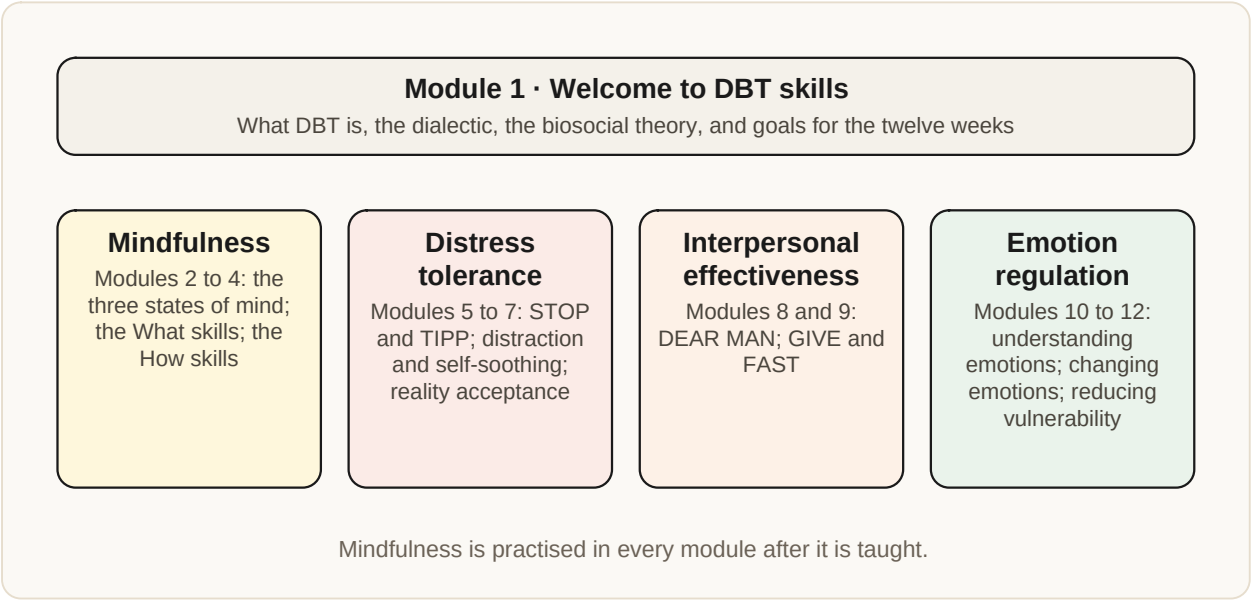


FIGURE 1.3 The four skill sets across the twelve modules
Module 1 orients the client to DBT and sets goals. Mindfulness comes next because every other skill depends on noticing what is happening; distress tolerance follows, so that the client has ways through a crisis early; interpersonal effectiveness and emotion regulation complete the programme, which ends with a plan for keeping the skills in use.

Each module has the same shape: an introduction, two to four teaching sections illustrated by two recurring characters, Maya and Daniel, a sorting task that checks understanding, one or two practice worksheets, and a short reflection (“Taking this forward”) that ends every module. The check-in questionnaires come in modules 1, 6 and 12. Maya is 34, works in the finance team of a housing association, lives with her partner Sam, and has always felt things quickly and strongly. Daniel is 41, supervises a shift at a distribution warehouse, and lives with his partner Leanne and their children, Josh and Ellie. Clients often find it easier to see a skill in Maya or Daniel before they can see it in themselves, and referring to their examples by name in the contacts is an efficient way to connect the teaching to the client’s own week.

CHAPTER 2

What the research shows

DBT as a whole treatment

DBT is the most researched of the specific psychological therapies for borderline personality disorder. A Cochrane review of psychological therapies for people with the diagnosis found that DBT had been tested in more randomised trials than any other single therapy, and that it was associated with reductions in the severity of difficulties and in self-harm, though the certainty of much of the evidence was rated low or very low (Storebø et al., 2020). Readers should hold both halves of that sentence: the evidence is the strongest available for this group, and it is not as strong as practitioners sometimes assume.

What the skills contribute

Two strands of research bear on a programme that teaches the skills alone. The first asks whether skills training is an active ingredient of full DBT. Linehan and colleagues (2015) compared standard DBT with two versions that each removed a component: DBT skills training with case management but no individual DBT therapy, and individual DBT therapy with no skills training. The conditions that included skills training did better than individual therapy without it on several outcomes, including the frequency of self-harm and symptoms of depression and anxiety. In a separate analysis of an earlier trial, Neacsiu, Rizvi and Linehan (2010) found that clients' use of the skills increased over treatment and partly explained the reductions in suicide attempts and depression and the improvement in the control of anger. Using the skills, not just having heard about them, appears to be part of how DBT works.

The second strand asks whether the skills help when they are taught on their own. Valentine and colleagues (2015) systematically reviewed studies of DBT skills training offered as a stand-alone treatment, across a range of difficulties, and found improvements in most of them, while noting that many studies were small and few were randomised. In a pilot randomised trial with adults whose anxiety or depression came with marked emotion dysregulation, skills training reduced emotion dysregulation and anxiety more than a supportive group did (Neacsiu et al., 2014).

What this means for the programme

The research supports three practical conclusions. Skills are learned by practice, in and between sessions, which is why each contact gives most of its time to what the client has practised (Lindenboim, Comtois and Linehan, 2007). Skills training appears to help people whose difficulties centre on emotion dysregulation even when they do not have, or do not want, a diagnosis of personality disorder. And a self-help version with brief support is a reasonable first step for people with mild to moderate difficulties of this kind, while people with frequent self-harm, chronic suicidal thoughts or severe dysregulation need the full treatment or another specialist service.

What the research does not show

No trial has yet tested this programme, or self-help DBT skills with brief guided support in this format, against a comparison condition. The evidence above comes from group skills training, mostly in specialist services, and from full DBT. The programme applies it carefully, with the stepping-up guidance in Part 2 as the safeguard for clients for whom it is not enough.